

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

05756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05755

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK	
c. LENGTH OF STAY IN lb 25 DAYS		d. STREET ADDRESS 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRENE MILES AUD		4. DATE OF DEATH Month APRIL Day 20 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 15, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PEARSON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LUTNER F. MILES		14. MOTHER'S MAIDEN NAME JANIE R. HAMMETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1919-56-1931		16. SOCIAL SECURITY NO. 219-56-1931	
17. INFORMANT B. FRANKLIN AUD		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Cardiac arrest DUE TO (b) Chronic heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hall bladder surgery		INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 month	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4/20/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE CEMETERY		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	
25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05756

1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SCOTLAND			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SCOTLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLORENCE Middle CULLISON Last BISCOE				4. DATE OF DEATH Month APRIL Day 17 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1881		9. AGE (In years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BENJAMIN HANDY				14. MOTHER'S MAIDEN NAME ELIZABETH TURNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 28 4647		17. INFORMANT MRS. HELEN WHITE - SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - (septuagenary) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 9160							INTERVAL BETWEEN ONSET AND DEATH instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7:00 4-17 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Scotland St Mary Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 4/19/67
ACTUAL SIGNATURE WM. D. BOYD		EXAMINER'S NAME (Type) WM. D. BOYD M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/20/67		23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM.		23d. LOCATION (City or town) (County) (State) RIDGE, MARYLAND	
24. FUNERAL DIRECTOR JOHN M. WELCH				25a. REC'D BY REGISTRAR APR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05758

CERTIFICATE OF DEATH

05757

1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ABELL c. LENGTH OF STAY IN 1b 6 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ABELL, MD d. STREET ADDRESS 18-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MARY BROOKS		4. DATE OF DEATH Month Day Year APRIL 12, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25, 1921
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MONTANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Corrosion of Liver DUE TO (b) Alcoholic DUE TO (c) 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 20, 1964 , to April 12, 1967 , that (I) (we) last saw the deceased alive on April 12, 1967 , and that death occurred at 3 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles Greenwell		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 15, 1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL, MARYLAND	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 1 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
05758					05758				
1. PLACE OF DEATH a. COUNTY ST. MARYS b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - HOLLYWOOD d. STREET ADDRESS RT: 2 BOX 338 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First NOAH Middle WASHINGTON Last CALLIS SR.					4. DATE OF DEATH Month APRIL Day 23 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/29/1885		9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARM OWNER		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W. CALLIS					14. MOTHER'S MAIDEN NAME ANN D. WHEATLY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217 36 5475A		17. INFORMANT MR. NOAH W. CALLIS JR.		Address HOLLYWOOD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Acidosis 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Pyelonephritis, acute DUE TO (c) Pyelonephritis, chronic								INTERVAL BETWEEN ONSET AND DEATH 1 wk. 3 wk. 5+ yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <i>John F. Fenwick</i>					M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/24/67		
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.					22d. ADDRESS LEONARDTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY JOY CHAPEL CEMETERY		23d. LOCATION (City, town or county) (State) HOLLYWOOD, MD.		
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MD.					25a. RECEIVED BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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RECEIVED BY MAIL
MAY 11 1961

APR 11 1961

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,			c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RUMXX MECHANICSVILLE 181		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS ROUTE 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MILES TAYLOR COLEMAN				4. DATE OF DEATH Month Day Year APRIL 7, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1906		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE DEPT.		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN COLEMAN				14. MOTHER'S MAIDEN NAME RUTH TILDEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 225-05-1505		17. INFORMANT DORIS ANN COLEMAN		Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 Anaphylaxis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive pulmonary disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE David Mossman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/18/67	
22c. PHYSICIAN'S NAME (Type) DAVID MOSSMAN M.D.				22d. ADDRESS MECHANICSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/11/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05761					05760						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY				
ST. MARYS		LEONARDTOWN			MARYLAND		ST. MARYS				
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
					RURAL - CHARLOTTE HALL						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?			
ST. MARYS HOSPITAL								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)											
First		Middle		Last		4. DATE OF DEATH		Month Day Year			
NETTIE		MAY		DAVIS		APR.		6 19 67			
5. SEX 6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.											
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		AUG. 6, 1883		83 yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE					DOMESTIC		MARYLAND		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
WM. W. DYSON					KATE MORAN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT				
NO					N/A		MRS. MARGARET LUMM				
							2153 PIERCE ST. NORTH ARLINGTON, VA.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central thrombosis</i>										instant	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Anterior cross</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary insufficiency, Cerebral thrombosis</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 19 60 to April 19 67, that (I) (we) last saw the deceased alive on April 19 67, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE										22b. DATE SIGNED	
DAVID L. MOSSMAN M.D.										4/8/67	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
MECHANICSVILLE, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF	
BURIAL										4/10/67	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)	
ALL FAITH CEMETERY										CHARLOTTE HALL, MARYLAND	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
JOHN M. WELCH - LEONARDTOWN, MD.										APR 11 1967 J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05762		05761	
1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown 181	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Saint Mary's Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Fenwick		4. DATE OF DEATH Month April Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-67
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. Months Days 18 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) St. Mary's County, Maryland
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Alvin Joseph Marshall	
14. MOTHER'S MAIDEN NAME Mary Ethel Fenwick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Leonardtown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (6 months) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town) (County) (State)		20e. (City or town) (County) (State)	
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20il. (City or town) (County) (State)		20im. (City or town) (County) (State)	
20im. (City or town) (County) (State)		20in. (City or town) (County) (State)	
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20iu. (City or town) (County) (State)		20iv. (City or town) (County) (State)	
20iv. (City or town) (County) (

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05763

CERTIFICATE OF DEATH

05762

1. PLACE OF DEATH a. COUNTY ST. MARYS b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK d. STREET ADDRESS 5 37 ESSEX DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PATRICK Middle LAMB Last GORDON M.D.				4. DATE OF DEATH Month APRIL Day 11 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/24/1873	
9. AGE (In years last birthday) 93 yrs.		10. FUNDER 1 YEAR Months 93 Days		11. FUNDER 24 HRS. Hours 93 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - MEDICAL DOC.				10b. KIND OF BUSINESS OR INDUSTRY MEDICINE			
11. BIRTHPLACE (County & State, or foreign country) CAMDEN, NORTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME THOMAS GEORGE GORDON				14. MOTHER'S MAIDEN NAME MARY ELIZABETH LAMB			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW I				16. SOCIAL SECURITY NO. 233 24 8216 A			
17. INFORMANT MISS ELLEN W. GORDON - SAME AS # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic vascular disease (b) Arteriosclerotic vascular disease (c) True monitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) True monitis						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 Feb 1967 to 4-11 1967 , that (I) (we) last saw the deceased alive on 4-11-67 , and that death occurred 4-11-67 from the causes and on the date stated above.							
22a. SIGNATURE J.C. Roa M.D.				22b. DATE SIGNED 4/11/67			
22c. PHYSICIAN'S NAME (Type) J.C. ROA M.D.				22d. ADDRESS LEXINGTON PARK, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 4/13/67		23c. NAME OF CEMETERY OR CREMATORY CHARLESTON, WEST VIRGINIA		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR JOHN M. WELCH				25a. REC'D BY REGISTRAR APR 14 1967			
25b. REGISTRAR'S SIGNATURE John M. Welch				25c. REGISTRAR'S NAME JOHN M. WELCH - LEONARDTOWN, MARYLAND			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05764

05763

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN IS 21 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS MORGANZA, RURAL	
3. NAME OF DECEASED (Type or print) WILLIAM MATHEW HOLT		4. DATE OF DEATH APRIL 16, 1967	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1896
9. AGE (In years lost birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HOLT		14. MOTHER'S MAIDEN NAME ADA DORSEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ETHEL M. HOLT		Address MORGANZA, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Tension and stress (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 4/19/67	
22c. PHYSICIAN'S NAME (Type) DAVID MOSSMAN M.D.		22d. ADDRESS GREAT HILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 20, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPH'S	23d. LOCATION (City or Town) (County) (State) MORGANZA, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR APR 21 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

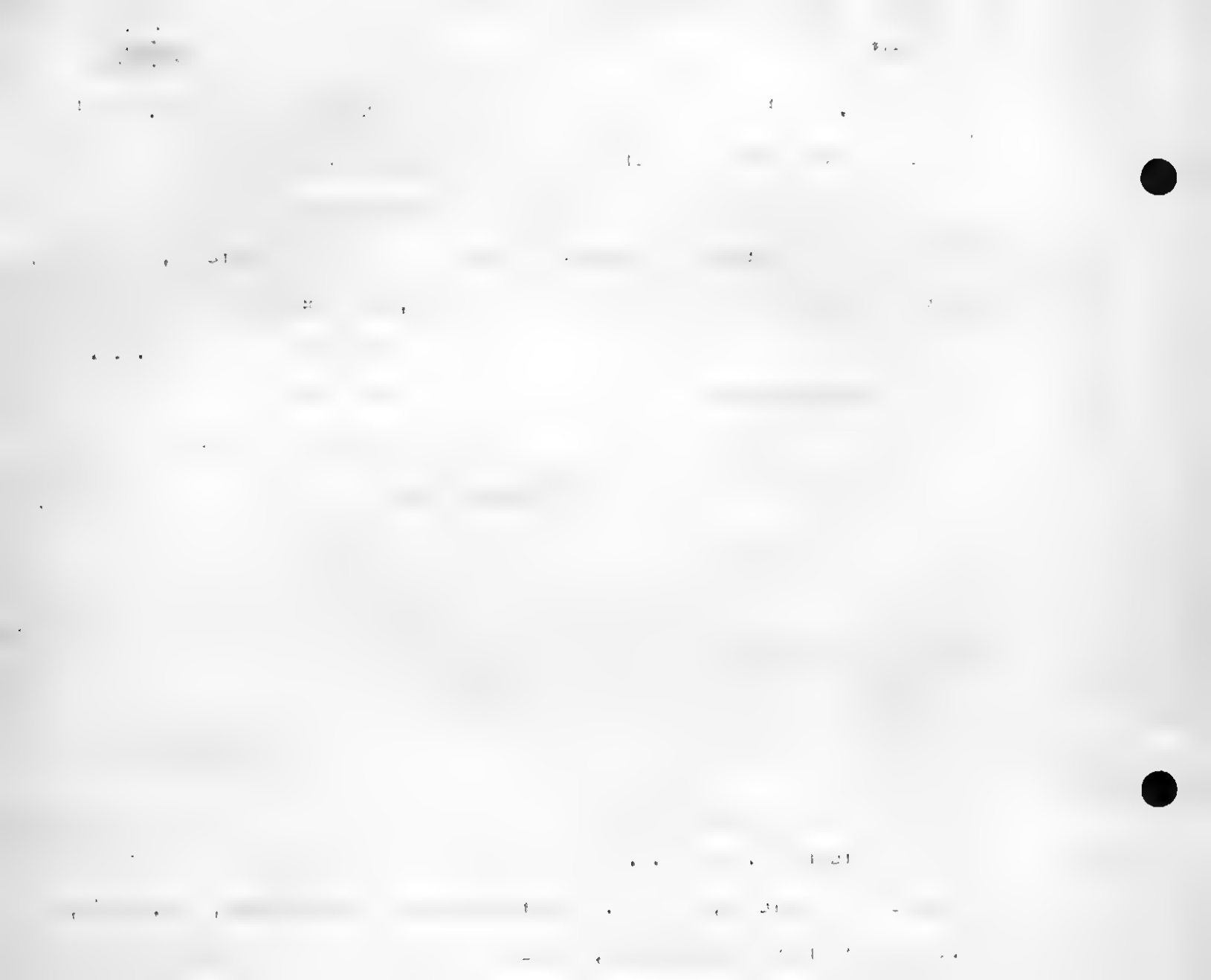
05765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05764

1 PLACE OF DEATH a COUNTY ST. MARY'S MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY ST. MARY'S			
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL LEXINGTON PARK				c LENGTH OF STAY IN 1b LIFE			
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last THELMA THERESA HURT				4 DATE OF DEATH Month Day Year APRIL 13, 1967			
5 SEX FEMALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH MARCH 12, 1967	9 AGE (In years lost birthday) 8 days yrs	10 UNDER 1 YEAR Months Days Hours Min 1 1		11 OVER 24 HRS Months Days Hours Min 1 1
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY MARKLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS STEWART				14. MOTHER'S MAIDEN NAME BARBARA HURT			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT MOTHER SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 4/15/67
ACTUAL SIGNATURE William D. Boyd M.D. EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF APRIL 14, 1967		23c NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY		23d LOCATION (City or town) (County) (State) LEONARDTOWN, ST. MARY'S, MD	
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a REC'D BY REGISTRAR APR 18 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

7-215317



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

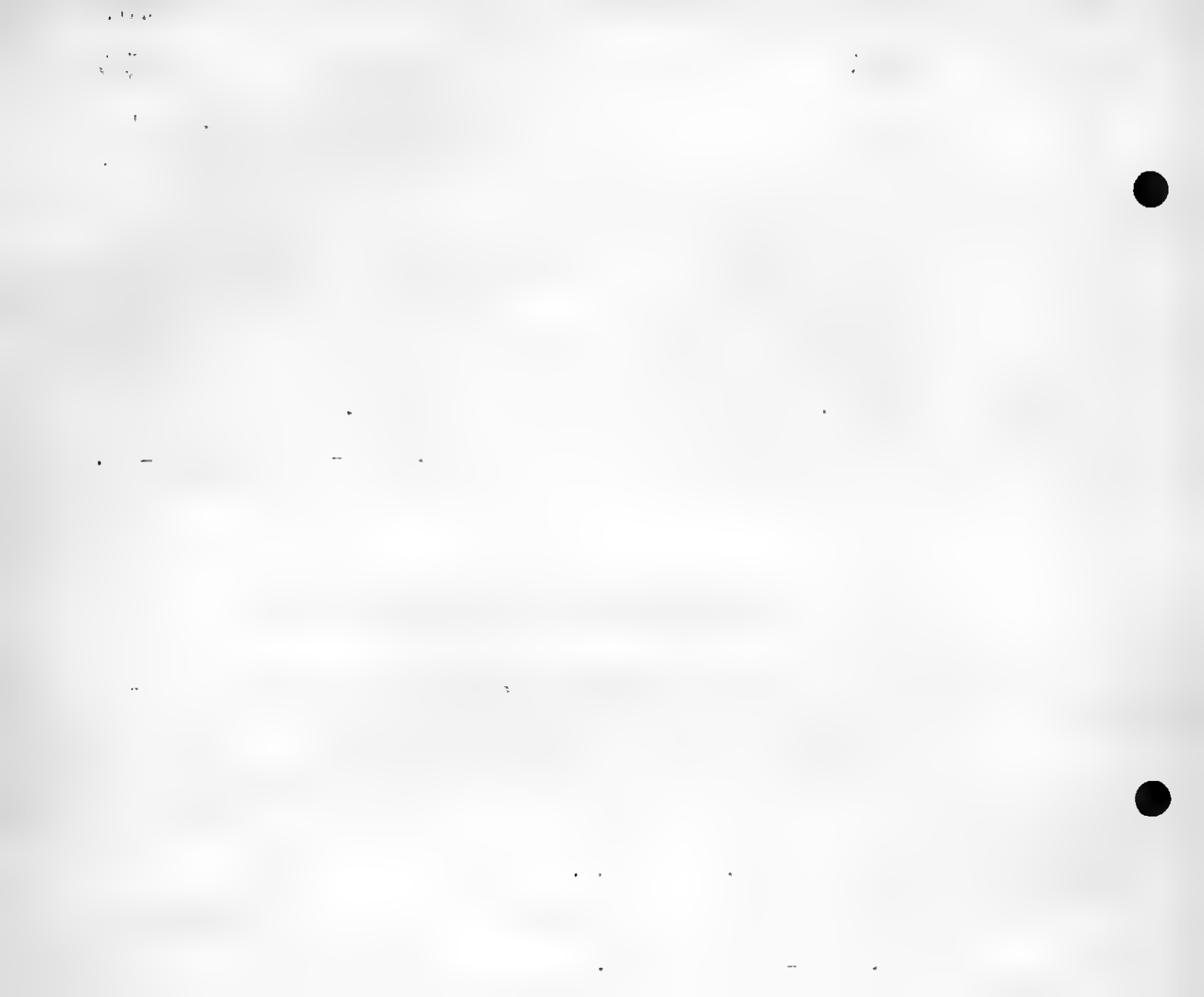
07206

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY St. Mary's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Gardiner's Mill c LENGTH OF STAY IN 1b Found: in stream or water on Mechanicsville-Chaplico Road		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY St. Mary's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell d STREET ADDRESS Found: in stream or water on Mechanicsville-Chaplico Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOSEPH KENNETH JONES		4 DATE Found: Month Day Year 4 25 19 67	
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-17-02 9 AGE (In years last birthday) 64 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY OYSTER & FISH	
11. BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES D. JONES		14 MOTHER'S MAIDEN NAME ANN E. HOPPS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 220 16 4656	
17. INFORMANT MARY L. MACK - COLTON POINT - MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I a. Part I. of Item 1B) Pedestrian - Presumably struck by auto then thrown in stream	
20c TIME OF INJURY Month Day, Year Hour a.m. Unknown 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e PLACE OF INJURY (Home farm factory street office plug etc) Unknown	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 5-5-67	
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF 5/8/67	23c NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY	23d LOCATION (City or Town) (County) (State) BUSHWOOD, MARYLAND
24a REG'D BY REGISTRAR JOHN M. WELCH - LEONARDTOWN, MD.		25a REC'D BY REGISTRAR MAY 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

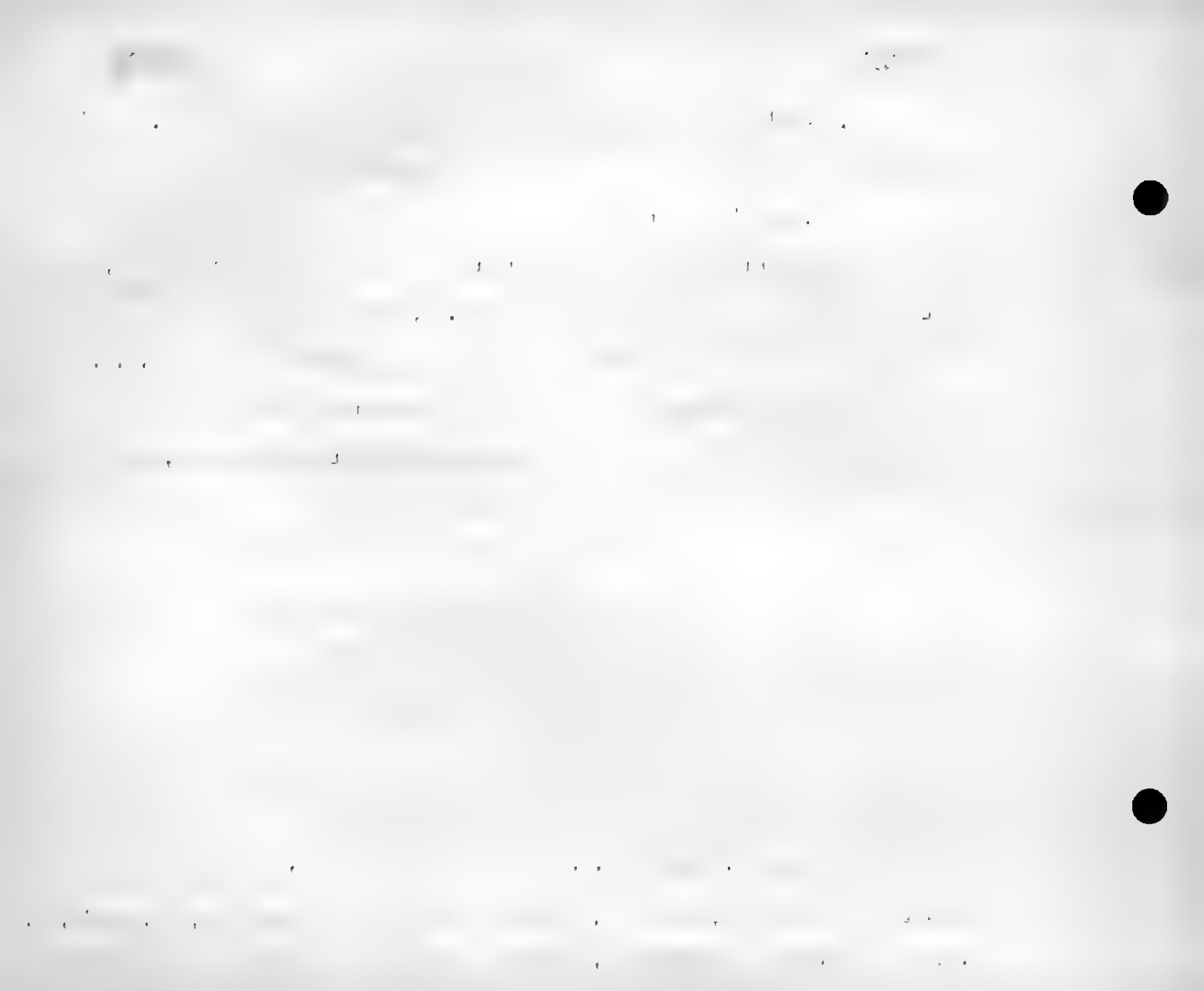
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05766

CERTIFICATE OF DEATH

05765

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) LEONARDTOWN		c LENGTH OF STAY IN 1b LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS LEONARDTOWN	
3 NAME OF DECEASED (Type or print) MARY ELIZABETH ABELL MATTINGLY		4. DATE OF DEATH Month APRIL Day 16 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ENOCH BOOTH ABELL		14. MOTHER'S MAIDEN NAME KATHERINE CAMALIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS ELOISE STOKEL LEONARDTOWN, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John P. Fenwick		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) JOHN P. FENWICK M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 18, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY	23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR APR 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

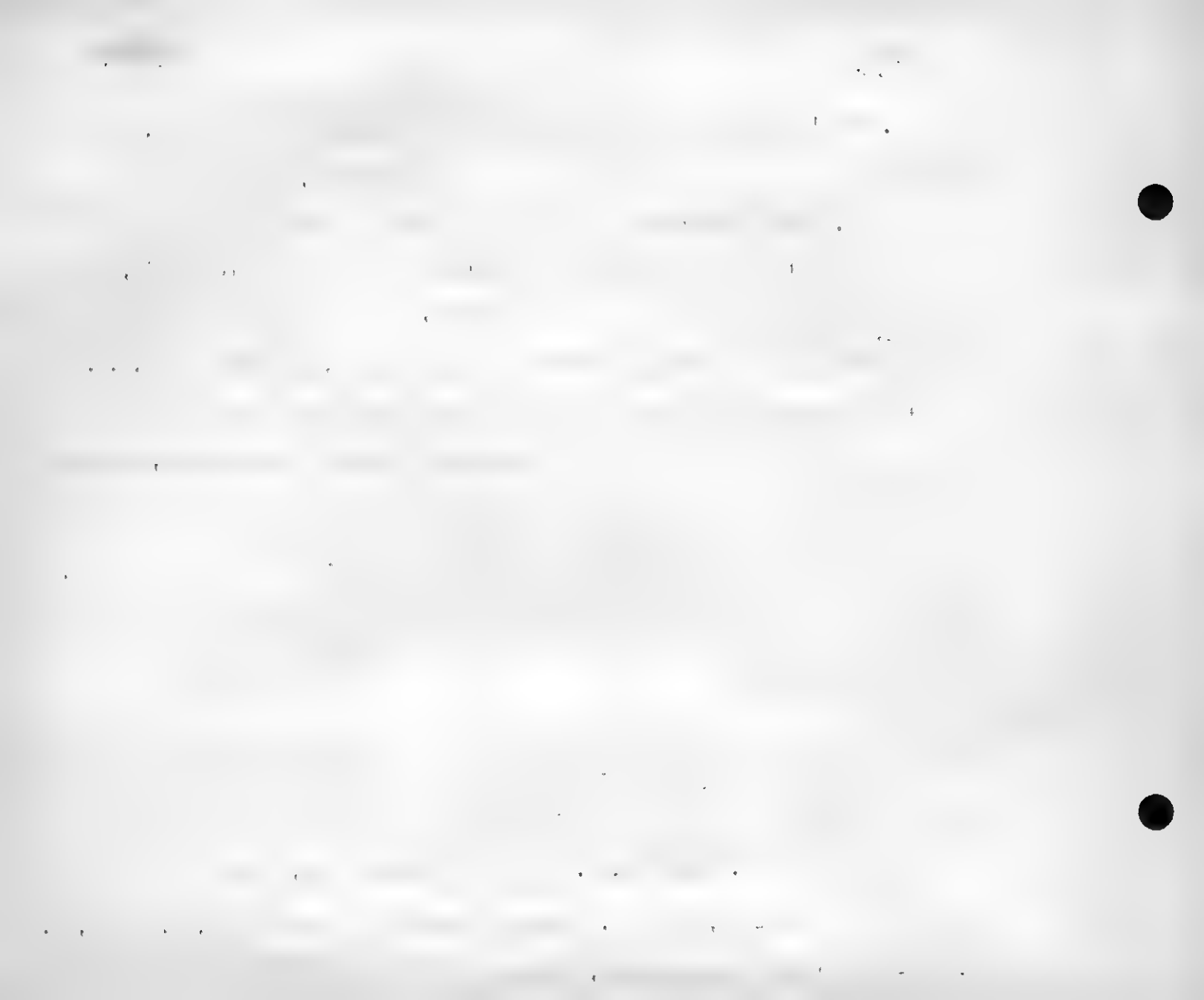
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05767

CERTIFICATE OF DEATH

05766

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c LENGTH OF STAY IN lb 20 HRS			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d STREET ADDRESS LAWRENCE AVENUE			
3 NAME OF DECEASED (Type or print) WILLIAM DOMNICK MATTINGLY				4 DATE OF DEATH APRIL 11, 1967			
5 SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JUNE 4, 1886	9 AGE (In years last birthday) yrs 80	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b KIND OF BUSINESS OR INDUSTRY FARM EQUIPMENT		11 BIRTHPLACE (County & State, or foreign country) LEONARDTOWN, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CLEMENT MATTINGLY				14. MOTHER'S MAIDEN NAME MARY MAGDALENE HAYDEN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO.		17 INFORMANT Address AMANDA MATTINGLEY LEONARDTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exsanguination DUE TO Ruptured Aortic Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerosis (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH min hrs							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/11/67 to 4/11/67 that (I) (we) lost the deceased alive on 4/11/67 and that death occurred at 4:50 PM from causes and on the date stated above							
22a SIGNATURE James P. Jarboe M.D.				22b. DATE SIGNED 4/11/67		22c PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D.	
22d ADDRESS LEONARDTOWN, MARYLAND							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF APRIL 14, 1967		23c NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY		23d LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MD.	
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a REC'D BY REGISTRAR APR 18 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05768

CERTIFICATE OF DEATH

05767

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEXINGTON PARK,	
3. NAME OF DECEASED (Type or print) First MACK Middle MUNGO Last MUNGO		4 DATE OF DEATH Month APRIL Day 27 Year 19 67	
5 SEX MALE	6 COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 5, 1878
9 AGE (In years last birthday) 88 yrs		10 IF UNDER 1 YEAR Months 4 Days 1 Hours 30 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11b. KIND OF BUSINESS OR INDUSTRY LANCASTER, SOUTH CAROLINA U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LOUIS MUNGO	
14. MOTHER'S MAIDEN NAME MARGARET BLADNIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 251-86-6974	
16. SOCIAL SECURITY NO. 251-86-6974		17. INFORMANT MATTIE GATES LEXINGTON PARK, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: 4500 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Amputated Left Lower Extremity (b) Arteriosclerosis DUE TO 36 yrs (c) 4 days		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April, 1967 to 27 April, 1967 , that (I) (we) last saw the deceased alive on 27 April, 1967 , and that death occurred at 12 P.M. from causes and on the date stated above.			
22a. SIGNATURE Ernest Rehm		22b. DATE SIGNED 30 April 1967	
22c. PHYSICIAN'S NAME (Type) ERNEST REHM		22d. ADDRESS LEXINGTON PARK, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY Cross Road	23d. LOCATION (City or Town) (County) (State) Lancaster S.C.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR MAY 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

35769

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) VIOLET BEAN NORRIS		4. DATE OF DEATH Month APRIL Day 15 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1902
9. AGE (In years last birthday) yrs 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. BEAN		14. MOTHER'S MAIDEN NAME ELIZABETH EVANS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ELMER LEE NORRIS		Address STAR ROUTE Box 39	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Massive Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) Coronary Atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (his/her) attended the deceased from 4/15 , 19 67 , that (1) (we) last saw the deceased alive on 4/19 , 19 67 , and that death occurred at 2:30 PM, from causes and on the date stated above			
22a. SIGNATURE JAMES P. JARBOE M. D.		22b. DATE SIGNED 4/18/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 18, 1967	23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY	23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REG'D BY REGISTRAR 1967	
ADDRESS LEONARDTOWN, MARYLAND		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPARTMENT

05770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05769

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY CL		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) near Clydes Tavern			d. STREET ADDRESS 53 E. Rennel Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Helen Patricia PILKERTON			4. DATE OF DEATH (Pronounced) Month Day Year April 16, 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 24, 1945	9 AGE (In years lost b. rhday) yrs 21	IF UNDER 1 YEAR Months Days Hours Min 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME JOHN S. PILKERTON		
14 MOTHER'S MAIDEN NAME ELIZABETH DEAN			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16 SOCIAL SECURITY NO			17 INFORMANT JOHN S. PILKERTON		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple blunt and penetrating injuries of head, neck and thorax Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c) 182X					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stabbed and struck numerous times			
20c. TIME OF INJURY Month, Day, Year About 2:30 am 4-16 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods	20f. (City or town) (County) (State) St. Marys	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate M.D.			22. DATE SIGNED April 17, 1967		
EXAMINER'S NAME (Type) Charles S. Springate, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 20, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEMETERY	23d. LOCATION (City or Town) (County) (State) HOLLYWOOD, ST. MARY'S, MD.		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR DATE APR 21 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

057771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

057770

1 PLACE OF DEATH a. COUNTY ST. MARYS		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE MARYLAND b. COUNTY SOLICITORS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS		c. LENGTH OF STAY IN 1b RURAL - BRANDYWINE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RT. 1 BOX 34	
3 NAME OF DECEASED (Type or print) First Middle Last JOHNNIE PRESTON RIGSBEE		4 DATE OF DEATH Month Day Year APRIL 2 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/18/1929
9 AGE (in years last birthday) 38 yrs		10 IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b KIND OF BUSINESS OR INDUSTRY AUTO & TRAILER	
11 BIRTHPLACE (State or foreign country) NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME RUFUS RIGSBEE		14 MOTHER'S MAIDEN NAME ANNIE TAPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO	
17 INFORMANT MRS. CAROLYN M. RIGSBEE - SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Injuries (head & chest) Multiple Extremities DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) auto accident - Thrown from car	
20c TIME OF INJURY Month, Day, Year Hour 6:55 pm 4-2 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Route 134		20f (City or town) (County) (State) Clement St Mary Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion a death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WM. D. BOYD M.D.		22. DATE SIGNED 4/3/67	
EXAMINER'S NAME (Type) WM. D. BOYD M.D.		Address (Street, city, town or county) LEONARDTOWN, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b DATE THEREOF 4/4/67	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State) DURHAM, NORTH CAROLINA	
24. FEDERAL DIRECTOR John M. Welch		25a REC'D BY REGISTRAR APR 5 1967	
ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05772 Item #1d Film# 945 9/17/67 05771											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY ST. MARY, S						a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN						b. COUNTY ST. MARY, S					
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lawrence Avenue (Home)						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			BARNARD			INGHAM			SMITH		
4. DATE OF DEATH		Month		Day		Year					
		APRIL		27		1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/20/1900		66 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
PLUMBING & ELEC.				SELF EMPLOYED				WASHINGTON D.C.			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JAMES W. SMITH						EDITH INGHAM					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
NO				215 32 0299				MRS. DOROTHY W. SMITH			
								Address			
								LEONARDTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial Infarction											
DUE TO (b) Arteriosclerotic Heart Disease											
DUE TO (c) Diabetes mellitus											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				(City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.											
22d. ADDRESS											
LEONARDTOWN, MD.											
23a. BURIAL, CREMATION, Removal (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
BURIAL				4/30/67				CHRIST EPISCOPAL CEM.			
23d. LOCATION (City, town or county)				23e. LOCATION (City, town or county)				23f. LOCATION (City, town or county)			
PORT REPUBLIC				PORT REPUBLIC				MD.			
24a. GENERAL DIRECTOR				24b. REGISTRAR'S SIGNATURE				25a. REC'D BY REGISTRAR			
JOHN M. WELCH				LEONARDTOWN MD.				DATE MAY 2 1967			
								25b. REGISTRAR'S SIGNATURE			
								J. Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05773

CERTIFICATE OF DEATH

05773

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Res dence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HOLLYWOOD		c LENGTH OF STAY IN lb 17 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last FRANCIS LUCILLE SMITH		4. DATE OF DEATH Month Day Year APRIL 13, 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1905
9 AGE (In years last birthday) yrs 62		IF UNDER 1 YEAR Months Days Hours Min 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CHARLOTTE, NORTH CAROLINA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR D. VANDERBURGH		14 MOTHER'S MAIDEN NAME MINERVA L. HAYES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT HAROLD J. SMITH		Address HOLLYWOOD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarct DUE TO (b) Coronary Thrombosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary atherosclerosis from calcification of the arteries			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18) Obvious	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a SIGNATURE A. Samadi		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) A. SAMADI M. D.		22d ADDRESS LEONARDTOWN, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF APRIL 16, 1967	23c NAME OF CEMETERY OR CREMATORY MT. ZION	23d. LOCATION (City or Town) (County) (State) LAUREL GROVE, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DATE APR 18 1967	
25b. REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05772

1 PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PARK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GREAT MILLS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS RT. 1 BOX 402	
3 NAME OF DECEASED (Type or print) DENNIS LEE STANLEY		4 DATE OF DEATH Month APRIL Day 13 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1963
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 13 Min 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (State or foreign country) BRISTOL, TENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELLIS LEE STANLEY		14. MOTHER'S MAIDEN NAME MARY ANN THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO N/A	
17. INFORMANT MRS. MARY ANN STANLEY - SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CRUSHING HEAD INJURIES EXTREME DUE TO (b) 634 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) VEHICLE LEFT HWY. STRIKING BRIDGE ABUTMENT		INTERVAL BETWEEN ONSET AND DEATH IMMED.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) VEHICLE LEFT HWY. STRIKING BRIDGE ABUTMENT	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:18 P.M. 4/13/67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) STATE RT. # 5		20f. (City or town) (County) (State) PARK HALL ST. MARYS MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WM.D. BOYD M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) LEONARDTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/17/67	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION (City or town) (County) (State) WALDORF, MARYLAND	
25a. REC'D BY REGISTRAR DATE APR 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

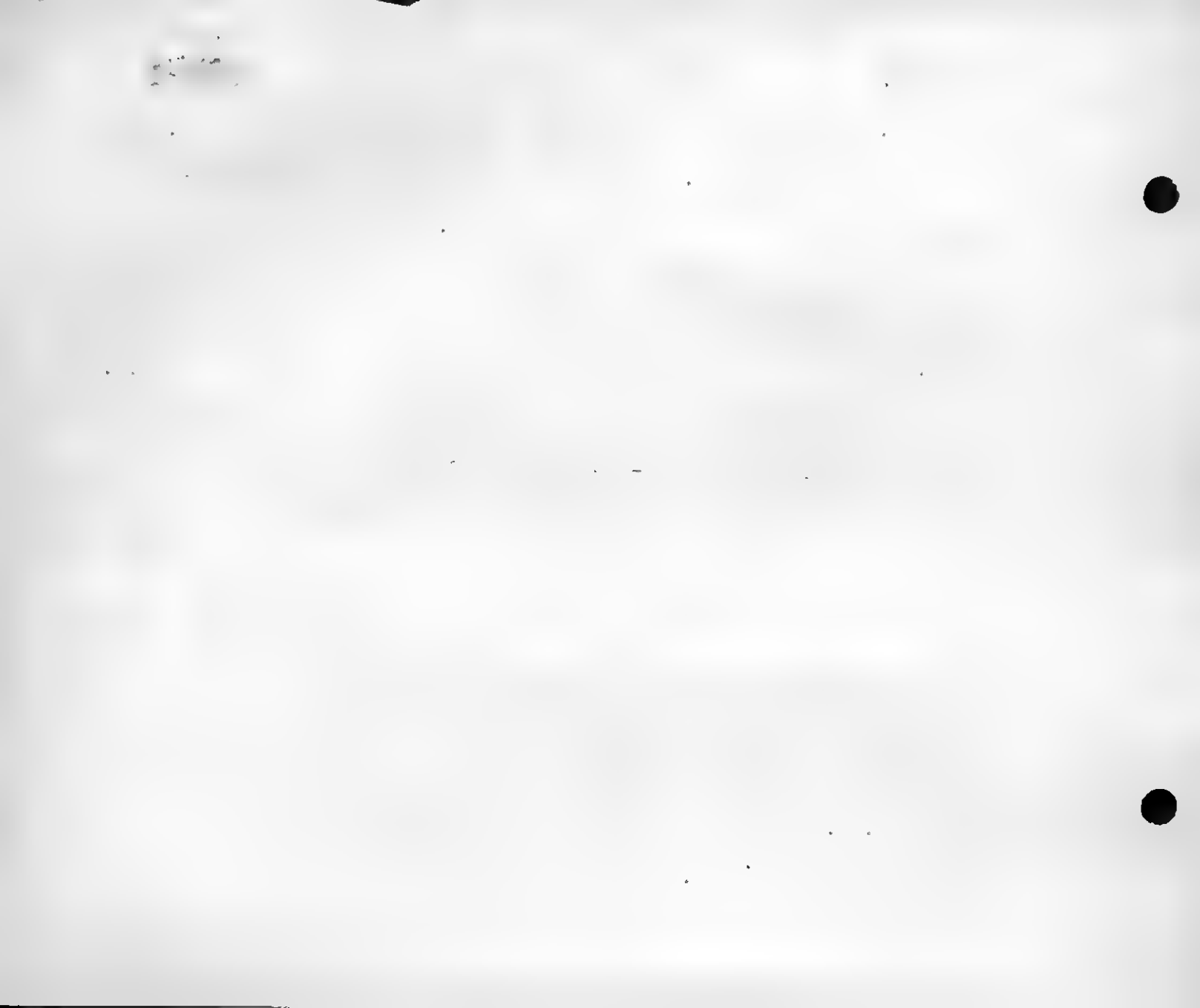
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

05775

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05774

1 PLACE OF DEATH a COUNTY St. Mary's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland/ Va. b. COUNTY St. Mary's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS, Patuxent River, Md.		c LENGTH OF STAY IN Ia 3 weeks	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nas, Patuxent River, Maryland		d STREET ADDRESS Bks // 411/ 5650 Fenwick Dr.	
a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Joseph Edward VORNBAUM		4. DATE OF DEATH April 7 1967	
5. SEX Male	6 COLOR OR RACE Caucasian	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 36 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11 BIRTHPLACE (State or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME William VORNBAUM (Deceased)		14 MOTHER'S MAIDEN NAME Helen (Foljinski) VORNBAUM (Deceased)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16 SOCIAL SECURITY NO 3 JUN 63-7 APR 67 144-24-0513	
17 INFORMANT Official Naval Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypoxia (cause undetermined) 7/5/67 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f ((city or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE C. F. MACGARRY, LT MC USNR M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. B. BOID, MD., County Coroner		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 7 APR 67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/11/67	
23c NAME OF CEMETERY OR CREMATORY Mt. Comfort Cemetery		23d LOCAT ON (City or Town) (County) (State) Fairfax Co. Va.	
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home, Alex. Va.		25a REC'D BY REG STRAP APR 17 1967	
ADDRESS		25b REGISTRAR'S SIGNATURE J. Charles Judge	



CERTIFICATE OF DEATH

05776

05775

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN	
c. LENGTH OF STAY IN 1b 3 DAYS		d. STREET ADDRESS MEDLEY'S NECK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES H. WALLACE		4. DATE OF DEATH APRIL 7, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7 1886
9a. AGE (In years last birthday) 80 yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hollywood Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXX TAHLWOOD WALLACE		14. MOTHER'S MAIDEN NAME SARAH GATTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MACE FORD		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CVA DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 67 , to 4-7 , 19 67 , that (I) (we) lost saw the deceased alive on 4-7 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE W.D. Boyd		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 10, 1967	23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL	23d. LOCATION (City or Town) (County) (State) MEDLEY'S NECK, ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR APR 11 1967	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05777					05776						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY ST. MARYS MARYLAND					a. STATE MARYLAND b. COUNTY ST. MARYS						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DAMERON					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - DAMERON 181						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS						
					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			CATHERINE		ANN		WOOD		Month APRIL Day 21 Year 19 67		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/13/1940		27 yrs.		Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						MARYLAND			USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
HARRY E. WOOD					HATTIE C. Mc KAY						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			N/A		MRS. HATTIE C. McKAY			SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse										hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Sepsis										days	
(c) Pneumonia										hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Retardation										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
Hour a.m. p.m. 19			While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work								
21. I certify that (I) (the hospital) attended the deceased from 4/21/67 to 4/21/67 , that (I) (the hospital) saw the deceased alive on 4/21/67 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE J.P. Jarboe					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/21/67		
22c. PHYSICIAN'S NAME (Type) J.P. JARBOE M.D.					22d. ADDRESS GREAT MILLS, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
BURIAL			4/24/67		ST. MICHAELS CEM.		RIDGE, MARYLAND				
24. FUNERAL DIRECTOR John M. Welch					ADDRESS JOHN M. WELCH - LEONARDTOWN, MD.		25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...		

03770

03770